The separation of the medical schools at St. Thomas's and Guy's was, Mr. Parsons thinks, inevitable from the first. He produces some evidence to show that the immediate cause of the separation lay in the characters of the two treasurers—Harrison at Guy's, an active, masterful man who knew every detail of the hospital work and looked upon the members of the medical staff as his servants; Abel Chapman, an expert man of business who was more interested in the finances of the hospital than in the medical side of its work. The medical school at St. Thomas's appears to have been an integral part of the hospital, as the lecturers were appointed directly by the governors, sometimes without even the formality of advertising a vacant post. The men appointed were too often quarrelsome, and there was little or no *esprit de corps*. It is not surprising, therefore, that although the school continued for some years, the change of site and temporary premises led to a lamentable falling off in the number of students. There were only twelve first-year men attending the March examinations in 1863, and in 1869 there were but sixteen. The numbers rose rapidly when the hospital again had a settled home, and in 1881 there was a total entry of ninety-six.

Mr. Parsons throws an interesting sidelight upon the lack of supervision which must have existed in connexion with the hospital expenditure. The apothecary, who performed the duties of medical superintendent, received in 1863 942 gallons of porter and thirty-six tons of coal for the use of his own household. A committee was appointed to inquire into the matter, and he was able to show that for thirty years he had used this amount of porter and coals, and had therefore accepted a lower salary than was his due. It is recorded a few years earlier that Roman Catholic and Jewish ministers were allowed to attend the patients when they were required, but "dissenting ministers were excluded because they excited the patients." Like the former volumes, there are numerous illustrations, the portraits of Sir John Simon, Dr. Bristowe, and Sir William MacCormac being especially good. There is a complete index to the whole work, and the price is so reasonable that every student of St. Thomas's Hospital should buy a copy.

D'A. P.

ANTI-GAS MEASURES

APPOINTMENT OF MEDICAL INSTRUCTORS

An announcement is made by the Air Raid Precautions Department of the Home Office (5, Princes Street, Westminster, S.W.1) of the appointment of ten doctors to be medical instructors in anti-gas measures. These medical instructors, who will be stationed in London and at suitable centres throughout the country, including Scotland, will be employed to give anti-gas training to medical practitioners, medical students, and nurses.

The arrangements with regard to medical students will be made through the Deans of the various medical schools, and the training of nurses will be arranged through the training facilities provided by the College of Nursing. With regard to practising doctors it is hoped that courses of training will be organized through the branches of the British Medical Association, though they will not, of course, be limited to members of that Association.

The newly appointed medical instructors will be given final training at the Civilian Anti-Gas School during the course of the next few weeks, and it is intended that they should begin their work in October.

Further announcements with regard to the arrangements which will be made will be given in the medical press.

According to official statistics the number of medical practitioners in Holland rose from 2,322 in 1905 to 3,548 in 1934, and of specialists from 347 to 1,241 in the same period. At the end of 1934 Holland contained 5,886 doctors, including officers in the Armies and State institutes, and another 1,200 were in practice in the Dutch Indies, 700 of whom had been qualified in Holland. About 30 per cent. of Dutch medical students do not finish their studies. In 1934 Holland had one doctor to every 1,720 inhabitants.

THE AMERICAN BOARD OF INTERNAL MEDICINE

The American Board of Internal Medicine, incorporated on February 28th, 1936, completed its organization on June 15th. The officers chosen were Dr. Walter L. Bierring (Des Moines), chairman; Dr. Jonathan C. Meakins (Montreal), vice-chairman; and Dr. O. H. Perry Pepper (Philadelphia), secretary-treasurer. These officers, with six other representative medical men in the United States, constitute the present membership of the Board.

The organization of the Board is the result of efforts on the part of the American College of Physicians in conjunction with the Section on Practice of Medicine of the American Medical Association, and these two organizations are represented in the membership of the Board on a five to four ratio. The Board had previously received the official approval of the two bodies fostering its organization, as well as that of the Advisory Board for Medical Specialties and the Council on Medical Education and Hospitals of the American Medical Association.

Certification in Internal Medicine

The purpose of the Board will be the certification of specialists in the field of internal medicine, and the establishment of qualifications with the required examination procedure for such certification.

While the Board is at present chiefly concerned with the qualification and procedure for certification in the general field of internal medicine, it is intended to inaugurate immediately after July 1st, 1937, similar qualification and procedure for additional certification in certain of the more restricted and specialized branches of internal medicine, as gastro-enterology, cardiology, metabolic diseases, tuberculosis, allergic diseases, etc. Such special certification will be considered only for candidates who have passed at least the written examination required for certification in general internal medicine. The operation of such a plan will require the active participation and co-operation of recognized representatives from each of such special fields of medicine.

Standards for Admission to Examination

Each applicant for admission to the examination in internal medicine will be required to meet the following standards:

General Qualifications.—(1) Satisfactory moral and ethical standing in the profession. (2) Membership of the American Medical Association or, by courtesy, membership of such Canadian or other medical societies as are recognized for this purpose by the Council on Medical Education and Hospitals of the American Medical Association.

Professional Standing.—(1) Graduation from a medical school of the United States or Canada recognized by the Council on Medical Education and Hospitals of the American Medical Association. (2) Completion of an internship of not less than one year in a hospital approved by the same council. (3) In the case of an applicant whose training has been received outside the United States and Canada, his credentials must be satisfactory to the Advisory Board for Medical Specialties and the Council on Medical Education and Hospitals of the American Medical Association.

Special Training Required

Five years must elapse after completion of a year's internship in a hospital approved for intern training before the candidate is eligible for examination. Three years of this period must be devoted to special training in internal medicine. This requirement should include a period of at least several months of graduate work under proper supervision in anatomy, physiology, biochemistry, pathology, bacteriology, or pharmacology, particularly as related to the practice of internal medicine. This work may be carried on in any domestic or foreign medical school or laboratory recognized by the Council on Medical Education and Hospitals of the American Medical Association as offering appropriate facilities for this type of post-graduate experience; or it may include a period of at least several months of graduate work under

proper supervision in internal medicine or in its restricted and specialized branches in any domestic or foreign hospital, clinic, or dispensary recognized by the Council.

A period of not less than two years must be devoted to special practice in the field of internal medicine or in its more restricted and specialized branches. The Board does not propose to establish fixed rules for the preliminary training of candidates for certification in this field, but contents itself with outlining broad general principles, although such suggestions as are made must be subject to constant changes reflecting the dynamic nature of the specialty.

A sound knowledge of physiology, biochemistry, pharmacology, anatomy, bacteriology, and pathology, in so far as they apply to disease, is regarded as essential for continued progress of the individual who practises internal medicine. The mere factual knowledge of medicine and its basic sciences is not sufficient. The candidate must have had training in their use in furthering his understanding of clinical medicine. This implies practical experience under the guidance of older men, who bring to their clinical problems ripe knowledge and critical judgement. Preparation to meet this requirement adequately may be even more difficult to obtain than the so-called scientific training. It may, however, be acquired (*a*) by work in a well-organized hospital outdoor clinic conducted by competent physicians ; (*b*) by a prolonged period of resident hospital appointments likewise directed by skilled physicians ; (*c*) by a period of training in intimate association with a well-trained and critical physician who takes the trouble to teach and guide his assistant rather than to require him only to carry out the minor drudgery of a busy practice.

The Board does not consider it to the best interests of internal medicine to lay down rigid rules as to where or how the training outlined above is to be obtained. Medical teaching and knowledge are international. The opportunities of all prospective candidates are not the same. Some may have the opportunity of widening their knowledge by a period of study abroad. Others may be restricted to a comparatively narrow geographic area, and their detailed training must be obtained in short periods scattered over a long time. Although at least five years must elapse between the end of the first intern year and the time when the candidate is eligible to take the examination, a longer period is advisable. The Board wishes to emphasize that the time and training are but means to the end of acquiring a broadness and depth of knowledge which the candidate must demonstrate to the Board in order to justify it in certifying that he is competent to practise internal medicine as a specialty.

Method of Examination

The examination required of candidates for certification as specialists in internal medicine will comprise Part I (written) and Part II (practical or clinical). The written examination is to be held simultaneously in different sections of the United States and Canada and will include (*a*) questions in applied physiology, physiological chemistry, pathology, pharmacology, and the cultural aspects of medicine ; (*b*) questions in general internal medicine.

The first written examination will be held in December, 1936, and successful candidates will be eligible for the first practical or clinical examination, which will be conducted by members of the Board near the time for the annual session of the American College of Physicians at St. Louis in April, 1937. The second practical examination will be held at Philadelphia near the time of the annual session of the American Medical Association at Atlantic City in June, 1937.

Further information can be obtained from the chairman, Walter L. Bierring, M.D., 406, Sixth Avenue, Des Moines, Iowa, U.S.A.

A. Touraine and R. Duperrat (*Ann. de Derm. et de Syph.*, June, 1936, p. 545) have studied literature and work done on the spontaneous healing of skin cancer, and have formed the opinion that skin cancers occasionally regress and sometimes heal of their own accord. This occurrence, however, is so rare that it must not be considered in making a prognosis in such cases. The reason why regression should occur appears to be obscure, but they consider it to be due to a local reaction such as a degeneration of the cancer cells rather than a general reaction.

Ireland

Memorial to Dr. Thomas Hennessy

A proposal to found a memorial to Dr. Hennessy, who was Irish Medical Secretary of the British Medical Association from 1914 until his deeply regretted death on January 2nd, 1936, is announced in the following circular letter dated August 21st:

> It is felt by many of the friends of the late Dr. Thomas Hennessy that something concrete should be done to perpetuate his memory and in recognition of his work for the medical profession. Collectively and individually the profession owes a deep debt of gratitude to Dr. Hennessy. Directly or indirectly there are few of us who have not benefited from his labours during his twenty-odd years as Irish Medical Secretary.
>
> That his name and his work might not be forgotten a committee has been set up by the Council of the Irish Free State Medical Union (I.M.A. and B.M.A.) to collect funds for a memorial. The exact form that this should take has not been decided. It will depend upon the response to this appeal. It has been suggested that a " Hennessy Prize " for students of medicine who are the children of medical men or women would be a suitable form of memorial.
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> Subscriptions, no matter how small, will be welcomed by any of the undersigned, or by the honorary secretary at 18, Kildare Street, Dublin.
>
> C. J. MACAULEY (*Chairman*).
> J. P. SHANLEY (*Hon. Secretary*).
> J. C. MARTIN (*Medical Secretary*).

The committee entrusted with the memorial appeal is composed of: Sir E. Coey Bigger (Glenageary, Co. Dublin), Dr. T. B. Costello (Tuam), Dr. J. F. Falvey (Dublin), Dr. W. J. Gallagher (Invereske, Donegal), Professor R. J. Johnstone (Belfast), Dr. L. Kidd (Enniskillen), Dr. J. C. Loughridge (Belfast), Professor T. G. Moorhead (Dublin), Dr. W. W. Murphy (Inch, Co. Wexford), Dr. H. F. MacAuley (Dublin), Dr. D. F. MacCarthy (Crookstown, Co. Cork), Dr. D. MacErlean (Dublin), Dr. A. McBride (Castlebar, Co. Mayo), Dr. P. J. O'Dowd, T.D. (Cabra, Dublin), Dr. C. O'Malley (Galway), Senator W. O'Sullivan (Killarney), Dr. J. Power (Cahir, Co. Tipperary), Dr. W. Rahilly (Cork), and Dr. Robert J. Rowlette, T.D. (Dublin).

Vital Statistics for Northern Ireland

The Registrar-General's annual report for 1935 records an increased death rate in Northern Ireland in spite of favourable climatic conditions. The year was notable for the mildness of the early months and a total sunshine record well above the average. Nevertheless, the death rate was 14.4, an increase of 0.7 over that of the previous year. This was chiefly attributable to the exceptionally high mortality from epidemic diseases, the figures for measles, scarlet fever, and diphtheria being the highest ever recorded in Northern Ireland. A severe epidemic of measles in Belfast accounts to a considerable extent for the 420 deaths from that disease, as compared with 102 the previous year. There were 135 deaths from scarlet fever, 155 from diphtheria, and forty-one from typhoid and paratyphoid fevers, as against fifty-three, 114, and seventeen respectively in 1934 ; whooping-cough, however, showed a decrease. The total number of deaths from all causes was 18,592. Of these heart disease claimed the greatest number with 3,315, the highest figure in the series of ten years tabulated. Cancer showed a decrease from 1934, but not from previous years. The death rate from tuberculosis at 1.05 per 1,000 is the lowest recorded since Northern Ireland became a separate entity in 1922. The greater prevalence of the disease in cities is shown by the death rate figures—1.18 for urban and 0.97 for rural areas. Deaths from puerperal sepsis showed a rate of 2.22 per 1,000 births, the highest recorded since 1925. It is noteworthy that this figure coincides with a high mortality rate from scarlet fever. A table devoted to